Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Hepatitis C Agents (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Hepatitis C Agents (FA-PA).

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the patient currently receiving treatment with the requested drug?	Y N
2.	Is the requested drug Mavyret, Viekira Pak, Viekira XR, or Zepatier?	Y N
3.	Does the patient have end-stage renal disease (ESRD) or severe renal impairment (estimated glomerular filtration rate [eGFR] of less than 30 mL/min/1.73m2)?	Y N
4.	Is the request for a patient who failed prior treatment with an NS5A inhibitor-containing regimen (eg, Daklinza, Epclusa, Harvoni, Mavyret, Technivie, Viekira Pak, Viekira XR, Zepatier)?	Y N

5.	Epclusa and Vosevi are the preferred products for your patient's health plan. Can the patient's treatment be switched to Epclusa or Vosevi?	Y N
6.	Epclusa and Harvoni are the preferred products for your patient's health plan. Can the patient's treatment be switched to Epclusa or Harvoni?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date